GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Rhonda Medows, MD, Commissioner *Sonny Perdue, Governor*

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STATE OFFICE OF RURAL HEALTH
Advisory Board Meeting Minutes
Wednesday, March 8, 2006
State Office of Rural Health, Cordele, Georgia

Presiding:	Wayne Martin, Chairman
Present:	Charles Owens, Ex-Officio Dianne Banister Steve Barber William Bina, MD Jennie Wren Denmark W. Kent Guion Carlos Stapleton Kevin Taylor Stuart Tedders Cindy Turner Maria Warda
Absent:	Mary Ann Shepherd
ORHS Staff:	Tony Brown Sheryl McCoy
Visitors:	David Seagraves, CEO, Sumter Regional Hospital Comfort Green, Vice President, External Operations, Sumter Regional Hospital Rhett Partin, GHA, Center for Rural Health Education Charlotte Vestal, CFO, Crisp Regional Hospital Kathy Whitmire, Hometown Health Pam Reynolds, SOWEGA AHEC Denise Kornegay, Statewide AHEC

Welcome and Opening Remarks

The regular scheduled meeting of the State Office of Rural Health (SORH) Advisory Board was held on Wednesday, March 8, at the State Office of Rural Health, Cordele, Georgia. Chairman Wayne Martin called the meeting to order at 10:40 a.m. Mr. Martin welcomed everyone and acknowledged this is the first meeting attended by the nine newly appointed members. The Board members and the guests each gave a brief introduction.

Minutes of December 2, 2005, Meeting

The minutes of the December 2, 2005, Advisory Board Meeting was approved as submitted.

Wayne Martin – Spoke concerning the Indigent Care Trust Fund (ICTF) issue and explained that a twenty (20) member Committee was appointed by Commissioner Burgess to study the allocation options of the ICTF. He shared that in the meeting of the committee on Monday, March 1, 2006, the recommendation on the table was passed with only one dissenting vote. The allocation method states that the hospitals will be divided into nine groups and the allocated dollar amounts will be distributed among the hospitals within the assigned group. The six principles established by the committee are:

- DSH payment would be directed to those with proportionate share of patients
- DSH payment would be based on uncompensated care
- All hospitals reimbursements based upon uniform methodology
- DSH should be based on varifiable data
- DSH should maximize funding
- They would add no undue burden on any group of hospitals

Mr. Martin explained there will possibly be audits over the state conducted by the Department of Community Health (DCH). The facilities most likely to be audited are those with significant changes in the amount given over the past three years versus the amount to be given this year.

David Seagraves - Added that the members of the committee did not see the calculations for the hospitals prior to making their decision to support the plan. He also expressed that many of the hospitals are desperate to receive their funding. The approved process will be to present the plan to the DCH Board on Thursday, March 9, 2006, at their Board meeting and with their approval will be presented to the Center for Medicare and Medicaid Services (CMS) for their approval. It is anticipated the funds should be distributed as early as June, 2006.

Wayne Martin – Mr. Martin said that a request has been made to DCH and the Board to possibly make an interim payment to the hospitals that need immediate cash. He shared that the Upper Payment Limit (UPL) money may be available to the hospitals this month.

Mr. Martin welcomed Dr. Rhonda Medows and expressed appreciation for her taking the time to come to the Advisory Board meeting.

Dr. Rhonda Medows reiterated that it was a monumental ability for the ICTF committee to come to an agreement on Monday. Everyone has a need and not enough dollars to meet that need. She confirmed the UPL money is definitely coming down. She also confirmed that DCH has granted permission to give interim payments to the hospitals as Mr. Martin stated earlier.

Dr. Medows spoke briefly about her work history expressing that most of her work has been in urban settings and rural healthcare will be an interesting challenge. Dr. Medows has previously worked in hospital administration and with the Florida Medicaid program. Dr. Medows and her husband, a Family Practice physician, have three sons and reside in Peachtree City, GA.

Wayne Martin explained that hospitals have been under the DRG payment system since 1997 and the base rate has only changed about $1000.

Dr. Medows asked concerning contract negotiations, "Do you get to go back to the table every year?

Wayne Martin said it depends on the individual contract.

Kevin Taylor remarked that the Critical Access Hospitals (CAH) and small rural hospitals had in the past been provided a certain amount of protection from DCH by a Memorandum of Agreement that stated they would be held harmless and receive cost based reimbursement, and would not go below a certain threshold. It appears that protection under the CMOs no longer exist and their payment base, independent of the DRG, will potentially deteriorate based on the hospital's ability to negotiate a good contract. In summary, he would like to make sure reimbursement does not fall below those thresholds.

Dr. Medows shared that she had invited hospitals to come in to meet with her to discuss the negotiations and several have already met with her.

Vi Naylor explained that she was aware of the invitation but had not understood that the invitation was extended to everyone.

Dr. Medows assured the Board members that the invitation is open to all.

Wayne Martin remarked that the invitation is a tremendous offer.

Denise Kornegay shared her concern for the workforce projections and shortages and asked if the workforce issue is in the vision of DCH.

Dr. Medows stated that it is in the vision, however, pressing issues are to re-vitalize the policy piece, to re-vitalize the health initiative group; i.e., Minority Health, Women's Health, Men's Health, HIV, etc. She expressed it is vital that the department get people on board to get the job done. She stated announcement will be made soon of changes in several departments at DCH.

Wayne Martin shared his concern that the short duration of the terms of past commissioners effects issues that may be on the table and decisions are delayed because of the change.

Dr. Medows explained that succession planning has been missing. She said when someone goes into a new position, it is important to mentor and train successors.

Charles Owens shared several points of interest about the State Office of Rural Health (SORH):

- Fully staffed except for one vacancy in the Primary Care area
- Submitted four grants
  - (1) Migrant and Seasonal Farmworker Expanded Medical Capacity – Requested $346,000
  - (2) Migrant Continuation Grant –Requested $226,309
  - (3) State Office of Rural Health (SORH) – Requested $199,000
  - (4) Primary Care Office – Requested $195,000
- Working with State Medical Education Board (SMEB), Ben Robinson, to put together a proposal to develop a dental loan repayment program for rural dentists. We are contributing $50,000 to provide 2 scholarships to dentists.
- HPSA has 57 Primary Care applications in process, 33 dental and 6 mental

- HPSA is one of a few pilot states for the automated data entry system
- J-1 Visa Waiver Program has approved 3 Primary Care, 4 Primary Care/Specialty Care and 5 Specialist
- Currently there are 90 J-1 Visa Physicians serving in underserved areas
- 83 National Health Service Corp (NHSC) participants, 58 are in loan repayment and 25 are scholars
- FLEX program – The Executive Summary of the FLEX Program Review illustrates that the Critical Access Hospital (CAH) program saved hospitals from closure and drastically improved the cash flow. After the third or fourth year of participation in the program, they realized they had obtained a lot of knowledge and began to recognize their own efficiency. GHA and Hometown Health have helped to administer the quality of the CAH program, created networks, EMS and quality improvement. The evaluation will be disseminated widely to share the information.
- Have come to an agreement with CMS on a definition of rural and it works for all the CAH hospitals except Liberty and work is being done in the Legislature that will possibly address Liberty as rural
- Developing a Rural Healthcare Plan – first phase complete, 2nd phase in process
- Small Hospital Improvement Program (SHIP) grant due now

Tony Brown informed the Board that in the Migrant and Seasonal Farmworker Program there are six Federally funded sites and one state funded. The program has received 2.5 million dollars. A pilot state funded site will be added in Clinch County. There are 90 farms in Clinch County that utilize migrant workers. The pilot for Peach/Houston counties has not yet been completed.

Mr. Brown reported that the Georgia Department of Audits conducted a Performance Audit in May, 2003. In December, 2005, a follow-up was done to determine the actions taken to address the findings in the report from 2003. The findings addressed were:

1. Action to increase the number of counties served by the program
   The number of counties served has been increased to 25
2. Take steps to obtain more up-to-date information regarding number and location of migrant and seasonal farmworkers in the state
   Arrangements are being made to have a statewide enumeration study within the next year
3. Program should consider revising the dollar amount of its contracts based on the estimated number of farmworkers in the service area
   This recommendation is not feasible due to the federal grant guidelines that specify program funding is based upon proposed penetration into the community and the number of medical users served. The grant is a competing grant and funding decisions are based upon past performance
4. Program should hold providers responsible for meeting performance standards
   Established performance standards for all project sites based upon the type of services provided, developed a monthly tracking system that captures the programmatic data of each project site
5. Establish uniform procedures regarding the administrative activities of project sites
   Contracted with Draffin & Tucker to develop a uniform financial policies and procedures plan
   A uniform sliding fee scale will be used and updated annually
   Contracted with a marketing and advertising company to provide video and brochures for the migrant sites
   Curriculum for Outreach Centered Health Education (COCHE) training to be provided – Health Education for Outreach workers
   Summer Project – contracted with AHEC to provide a summer health fair to provide direct healthcare to migrant workers
   Interpretor training being provided

Mr. Brown shared that the Wilcox Site will be closing. The migrant population numbers weren't large enough to continue.

He explained the Federal regulations require the Migrant Program to have a Migrant Committee and hold quarterly meetings. A Migrant Sub-committee is in development.

Mr. Martin appointed Dr. Warda, Mary Anne Shepherd and Jennie Wren-Denmark to be members of the Migrant Sub-Committee. Mr. Martin also appointed a Nominating Committee for the purpose of selecting officers for the Advisory Board. Those appointed were, Dr. Guion, Dr. Tedders and Kevin Taylor. The committee is to bring to the Advisory Board two names for each office, Chair, Vice-Chair and Secretary. Each member drew a number of 1, 2 or 3 to determine the number of years they will serve on the Board.

Denise Kornegay, Statewide Area Health and Education Centers (AHEC) gave a presentation regarding factors that influence physician's practice location decisions. Examples are as follows:

- Positive residency and recruitment programs attracting female physicians in rural areas
- Inner-city based medical school program encourages students to practice in with urban underserved populations
- A combination of supervised patient care and classroom training in rural and cultural issues results in high percentages of those medical students choosing residencies and practice locations in rural areas
- Although debt is a factor in their career choice, the independent impact of debt on their choices in 2002 was statistically modest
- Canada recommends increasing the rural pipeline in high school and college, reducing financial barriers for rural students, and changing admissions policies to admit an equitable number of rural origin students
- The addition of a primary care clinical requirement to a family medicine requirement is associated with a higher production of family physicians
- Students who had lived in a rural area were most likely to elect to practice in rural areas
- Rural physicians and residents recommend increased locum support, sabbaticals at appropriate pay, and call limits as reforms that would increase recruitment and retention
- High school students shadowing health care professionals
- Rural communities are more likely to recruit female physicians if they address spouse-partner, childcare and scheduling issues during the recruitment process
- In 150 family practice residency programs that consider rural family practice an important part of their mission, only 2.3% of their training actually takes place in rural areas
- Urban-background medical students had negative opinions of most aspects of rural health care – Opinions based on information from the media
- The top three factors influencing practice location decision, urban and rural, were spousal influence, type of practice, and proximity to extended family

Ms. Kornegay's survey information showed women were less likely to choose rural areas. When workload projections are done, they are basing it on the workload of the baby boomer physicians who work 60 to 80 hours per week which is not realistic. Women indicated they need flexible child care centers, child care subsidy, support groups with other female rural physicians, funding for re-training after a break of service, such as, maternity leave. Ms. Kornegay remarked that she felt medical schools should address the gender issues and differences.

Ms. Kornegay concluded by stating Georgia is not looking at the data collectively and not layering the programs effectively. The question is, "How can we take what we know and make it happen?" To summarize, if we know

it takes a lot of exposure to rural areas for physicians to choose and establish a practice, then we must find ways to make it happen.

Dr. Guion shared about Federal funding, which encouraged students to go back to their communities to practice, that shows 70% of those students stayed in their communities for a long-term practice.

Dr. Medows shared that a positive for rural areas is the warmer, friendlier atmosphere. Another positive is to compare number of patients in a city; i.e., Chicago versus number of patients in a rural area. Another problem is retention. For example, typically after J-1 Visa Waiver is completed, the physicians desire to move to a bigger city.

Mr. Martin clarified that the members he appointed to the nominating committee are also eligible to serve as officers.

There being no further business or public comments, the meeting adjourned at 12:30 p.m.

Respectfully,

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Wayne Martin, Chairman/Date Sheryl McCoy, Recording Secretary/Date